

# Patient Medical History

NAME:			Age:			Date:					
<b>Chief Complaint</b>											
1. For what problem are you seeing the doctor today?											
<b>History of Present Illness</b>											
When did your problem, injury or pain begin?											
Is this a work-related injury or illness? <input type="checkbox"/> YES <input type="checkbox"/> NO						If yes, You MUST provide workers compensation information to OANNM.					
Were you seen in the Emergency Room?				Yes <input type="checkbox"/>		No <input type="checkbox"/>		Date:			
How did your problem start? (Please check all that apply.)		Suddenly <input type="checkbox"/>	During sports <input type="checkbox"/>	Fall <input type="checkbox"/>	Lifting <input type="checkbox"/>	Auto <input type="checkbox"/>	No apparent cause <input type="checkbox"/>				
		Over time <input type="checkbox"/>	At work <input type="checkbox"/>	Twisting <input type="checkbox"/>	Pulling <input type="checkbox"/>	Accident <input type="checkbox"/>					
Other (describe):											
What are your symptoms? (Please check all that apply.)		Pain <input type="checkbox"/>	Swelling <input type="checkbox"/>	Redness <input type="checkbox"/>	Bruising <input type="checkbox"/>	Spasm <input type="checkbox"/>	Weakness <input type="checkbox"/>				
		Tingling <input type="checkbox"/>	Locking <input type="checkbox"/>	Catching <input type="checkbox"/>	Giving Way <input type="checkbox"/>						
If you have pain, how would you describe it? (Please check all that apply.)		Constant <input type="checkbox"/>	Intermittent <input type="checkbox"/>	While at rest <input type="checkbox"/>	At night <input type="checkbox"/>						
		With Activity <input type="checkbox"/>	Burning <input type="checkbox"/>	Aching <input type="checkbox"/>	Sharp <input type="checkbox"/>	Dull <input type="checkbox"/>					
On average, how severe is your pain?		1	2	3	4	5	6	7	8	9	10
		No Pain					Worst Pain Imaginable				
What reduces your symptoms? (Please check all that apply.)		Sitting <input type="checkbox"/>	Lying down <input type="checkbox"/>	Standing <input type="checkbox"/>	Stopping sports or activities <input type="checkbox"/>						
		Walking <input type="checkbox"/>	Medication <input type="checkbox"/>	Physical Therapy <input type="checkbox"/>	Ice <input type="checkbox"/>	Heat <input type="checkbox"/>					
What makes your problem worse? (Please check all that apply.)		Sitting <input type="checkbox"/>	Standing <input type="checkbox"/>	Walking <input type="checkbox"/>	Coughing/Sneezing <input type="checkbox"/>						
		Bending <input type="checkbox"/>	Exercise (during) <input type="checkbox"/>	Exercise (after) <input type="checkbox"/>	Other <input type="checkbox"/>						
Have you had any diagnostic tests for this problem? (Please check all that apply.)		X-Rays <input type="checkbox"/>	CT scan <input type="checkbox"/>	MRI <input type="checkbox"/>	Injections <input type="checkbox"/>						
		Arthrogram (dye injection) <input type="checkbox"/>	Electromyogram (EMG) or Nerve Conduction Study (NCS) <input type="checkbox"/>								
Dates:		Place:		Delivered to OANNM?		With PT?					
<b>Review of Systems: Have you, the patient, ever had any of the following conditions? (Please check all that apply.)</b>											
Vision or hearing problems			Kidney disease/failure			Stroke					
Thyroid problems			Diabetes			Balance problems					
Asthma or emphysema			Bone or joint problems			Contagious conditions					
High blood pressure			Arthritis or rheumatism			HIV	TB	Hepatitis			
Heart Problems			Gout			Depression					
Bleeding problems			Osteoporosis			Weight Loss					
Blood Clots			Cancer								
Stomach Problems/ulcers/reflux			Skin Disorders								
Bowel or bladder problems			Seizures or epilepsy			NONE of the above					

**Past Medical History**

**Please list ALL previous surgeries, hospitalizations and/or broken bones:**

Surgery	Date		Surgery	Date
Surgery	Date		Surgery	Date
Surgery	Date		Surgery	Date

**Please list ALL your current medications and their doses. Include “over the counter” medications and herbals.**

Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose
Medication	Dose		Medication	Dose

<b>Are you allergic to any medications?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Please list medications causing allergic reactions:</b>  
<b>Are you allergic to Latex?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>Women Only: Are you, or could you be, pregnant?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Due Date?</b>	<b>Last menstrual period?</b>
--	------------------	-------------------------------

**Family History**

**Does any blood relative have a history of any of the following medical problems? (Check all that apply?)**

Rheumatoid Arthritis	Blood Clots	Diabetes
Cancer	Heart Disease	Problems with anesthesia
High Blood Pressure	Osteoporosis	Stroke
Other:	None of the above	

**Social History**

What is/was your occupation?	Employer:		
Do/did you use tobacco? Yes No	Type of tobacco?	How much?	Quit when?
Do you drink alcoholic beverages? Yes No	How many drinks per day?		
Do you use prescription pain medication or “street” drugs? Yes No	Which?		
Have you ever been addicted to prescription or non-prescription drugs? Yes No	Which?		
Do you live alone? Yes No	How often do you exercise?	Never Rarely	Daily Weekly Monthly
	What type of exercise?		

**Miscellaneous**

Were you referred here by a physician? Yes No	Physician Name:
Who is your primary care physician?	
Is there any legal action pending that pertains to your visit?	If yes, please describe:

**For Office Use Only**

Height	Weight	Pulse	Blood Pressure	Respirations	Reviewed by	Date
--------	--------	-------	----------------	--------------	-------------	------